IF YOU WANT TO KNOW MORE

Medicare Program Basics

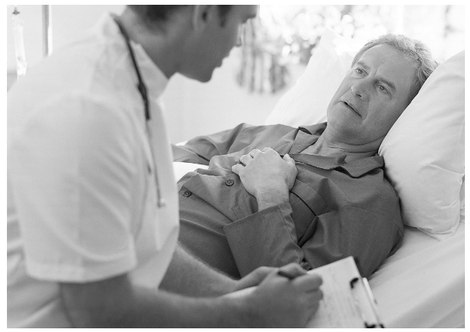
Medicare & You

Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure)

Medicare is administered by the **Centers for Medicare & Medicaid Services (CMS)**, a Federal agency in the U.S. Department of Health and Human Services. The Social Security Administration enrolls most people in Medicare.

You do not have to be retired to enroll in Medicare. You can enroll in Medicare up to 3 months before age 65. If you are already receiving Social Security benefits, you will be automatically enrolled.



MEDICARE HEALTH PLANS

Your health plan choices include:

- The Original Medicare Plan, available nationwide
- Medicare Advantage* Plans, available in many areas
- Medicare Prescription Drug Plans

Medicare has Three Parts:

- Part A (Hospital Insurance)
- Part B (Medical Insurance)
- Prescription Drug Coverage

What is Medicare Part A?

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, including critical access hospitals*, and skilled nursing facilities* (not custodial or long-term care). You must meet certain conditions to get these benefits.

Cost: Most people don't have to pay a monthly payment, called a premium, for Part A. This is because they or a spouse paid Medicare taxes while working.

If you don't get premium-free Part A, you may be able to buy it if:

- you (or your spouse) aren't entitled to Social Security, because you didn't work or didn't pay Medicare taxes while you worked and are age 65 or older, or
- you are disabled but no longer get free Part A because you have been working for a long time.

For more information, you can look at **www.socialsecurity.gov** or call the **Social Security Administration at 1-800-772-1213**. TTY users should call 1-800-325-0778.

What is Medicare Part B?

Medicare Part B (Medical Insurance) helps cover your doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists*, and some home health care.* Part B helps pay for these covered services and supplies when they are medically necessary.

Enrolling in Part B is your choice. You can sign up for Part B any time during your Initial Enrollment Period.* Coverage begins the first day of the month you turn 65, but will be delayed if you wait until you are 65 or later to apply.

If you do not choose Part B when you are first eligible, you may sign up during the **General Enrollment Period**,* January 1–March 31 each year. Coverage begins July 1 that year.

Cost: You pay the Medicare Part B premium each month. In some cases, this amount may be higher if you didn't sign up for Part B when you first became eligible. The cost of Part B may go up 10% for each full 12-month period that you could have had Part B but didn't sign up for it, except in special cases (Special Enrollment Period*). You will have to pay this extra amount as long as you have Part B.

You also pay a Part B deductible* each year before Medicare starts to pay its share. This amount will increase each year.

Medicare deductible and premium rates may change every year in January.

What is Medicare Prescription Drug Coverage?

Beginning January 1, 2006, new Medicare prescription drug coverage will be available to people with Medicare. (See **Medicare Prescription Drug Coverage** for more information). Everyone with Medicare is eligible to get Medicare prescription drug coverage to help lower prescription drug costs and help protect against higher costs in the future.

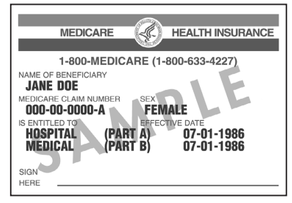
If you currently have Medicare Part A and/or Part B, you can join a Medicare prescription drug plan between November 15, 2005 and May 15, 2006. If you join by December 31, 2005, your Medicare prescription drug plan coverage will begin on January 1, 2006, and you won't miss a day of coverage. If you join after that, your coverage will be effective the first day of the month after the month you join. If you join a Medicare prescription drug plan after May 15, 2006, you are likely to pay a higher monthly premium unless you currently have a drug plan that covers as much as or more than a Medicare prescription drug plan.

Like other insurance, if you join, you will pay a monthly premium (generally around $37 in 2006) and pay a part of the cost of your prescriptions, including a copayment and deductible. Costs will vary depending on which drug plan you choose. Some plans may offer more coverage and additional drugs for a higher monthly premium. If you have a limited income and resources, and qualify for extra help, you may not have to pay a premium or deductible.

You Need to Make an Important Decision About Your Prescription Drug Coverage

The prescription drug coverage option you choose affects:

- **Coverage**
  Check to see if your current prescription drugs are covered to be sure your current treatment is not affected. Drug plans can cover different generic and brand name drugs in different drug categories. Some plans may cover additional drugs.
- **Cost**
  Find out how much the monthly premiums are for the Medicare prescription drug plans in your area, and what your share of the cost of your prescriptions would be. **Note:** If you have Medicare due to a disability, you can enroll in Medicare prescription drug coverage.
- **Convenience**
  Find out which pharmacies the drug plans in your area use to ensure that they are convenient to you.
- **Security**
  Decide what your future needs might be. Even if you don't use a lot of prescription drugs now, you still should consider joining a Medicare prescription drug plan in 2006. As we age, most people need prescription drugs to stay healthy.



You should protect your red, white, and blue Medicare card as if it were a credit card!

**Definition can be found in the glossary.*

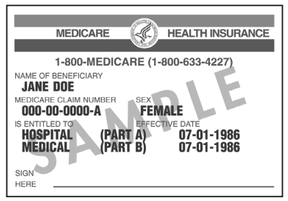
IF YOU WANT TO KNOW MORE

Original Medicare

Medicare & You

What is the Original Medicare Plan?

The Original Medicare Plan* is a "fee-for-service" plan. This means you are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care.


MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO:
HOSPITAL (PART A)
MEDICAL (PART B)

EFFECTIVE DATE
07-01-1986
07-01-1986

SIGN HERE

SAMPLE

If you are happy getting your health care through the Original Medicare Plan, you don't have to change to another Medicare health plan. You will stay in the Original Medicare Plan unless you choose to join another type of Medicare health plan.

How Does the Original Medicare Plan Work?

- You may go to any doctor or specialist who accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility. Generally, a fee is charged each time you get a health care service.
- If you have Medicare Part A, you get all the Part A-covered services. (See **Medicare Program Basics**.)
- If you have Medicare Part B, you get all the Part B-covered services. You usually pay a monthly premium for Part B.
- You pay a set amount for your health care (deductible*) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment*).
- After you get a health care service, each month you get a **Medicare Summary Notice*** in the mail. This notice is sent by companies that handle bills for Medicare. The notice lists the details of the services you received and the amount you may be billed.

Your Costs in the Original Medicare Plan

What you pay out of pocket depends on:

- whether you have Part A and/or Part B (most people have both).
- whether your doctor or supplier accepts "assignment*".
- how often you need health care.
- what type of health care you need.
- whether you choose to get services or supplies not covered by Medicare. In this case, you would pay for these services yourself.
- whether you have other health insurance coverage.

Medicare doesn't cover all of your costs for health care. There are many types of coverage that may pay for some or all of the costs not covered by Medicare, including:

- Coverage for employees and/or retirees from an employer or union.
- **Medigap Insurance***, also known as **Medicare Supplement Insurance**, from a private insurance company.

If you can't afford to pay for Medicare premiums, deductibles, or co-payments or coinsurance, there are programs, such as **Medicare Savings Programs***, that can help.

What Isn't Paid for by Medicare Part A and Part B in the Original Medicare Plan?

In most cases, Medicare does **not** cover:

- Custodial care*
- Deductible, coinsurance, or co-payments
- Dental care and dentures
- Cosmetic surgery
- Acupuncture
- Health care while traveling outside the U.S.
- Hearing aids and hearing exams (screening)
- Routine eye care and most eyeglasses
- Long-term care*, such as non-skilled care in a nursing home (most nursing home care is non-skilled care, such as help with dressing, bathing, or eating, and is **not** covered by Medicare)

What is "Assignment" in the Original Medicare Plan and Why is it Important?

Health care providers must submit claims to Medicare. The **Centers for Medicare & Medicaid Services (CMS)** works with private companies, called Medicare contractors to process these claims.

For most services, Medicare sets a limit on the amount your health care providers can charge. Doctors and suppliers who always accept the Medicare-approved amount as payment in full (called "accepting assignment") are said to participate in Medicare. If your provider does not accept assignment, you may have to pay more and/or pay at the time of service.

What is a Medigap Policy?

The Original Medicare Plan pays for many health care services and supplies, but it doesn't pay all of your health care costs. There are costs that you must pay, like coinsurance, copayments, and deductibles. These costs are called "gaps" in Medicare coverage. You might want to consider buying a Medigap policy to cover these gaps in Medicare coverage. (See **Medigap** and **Other Supplemental Insurance** for more information.)

How Does the Original Medicare Plan Work with a Medigap Policy?

- You may go to any doctor or specialist (unless you buy a Medicare SELECT* policy). Medicare pays its share, and then your Medigap policy pays its share. What your Medigap policy covers depends on which plan (A–L) you buy. However, Medigap policies generally cover coinsurance, copayments and deductibles.
- You pay your monthly Medicare Part B premium, and you pay the insurance company a monthly premium for your Medigap policy.
- After you get a health care service, each month you will get a **Medicare Summary Notice** in the mail and your Medigap insurance company will send you information on what it paid on your behalf.

What if I Have a Limited Income and Can't Afford a Medigap Policy?

There are other types of programs that might help you pay costs Medicare doesn't cover. (See **Medigap** and **Other Supplemental Insurance** for more information.)

What is a Medicare Prescription Drug Plan?

Beginning January 1, 2006, new Medicare prescription drug plans will be available to people with Medicare. (See **Medicare Prescription Drug Coverage** for more information.)

How Does the Original Medicare Plan Work with a Medicare Prescription Drug Plan?

- You pay a separate monthly premium for your prescription drug plan.
- You pay a share of your prescription drug costs, and your plan pays a share.
- Medicare pays your plan a monthly amount to help pay for your prescription drug coverage.
- You get a prescription card from your Medicare prescription drug plan. Show it when you get your prescriptions filled.
- You must go to pharmacies that belong to the plan.

What if I Have a Limited Income and Can't Afford a Medicare Prescription Drug Plan?

People with Medicare and Medicaid, and other people with limited incomes and resources can qualify for help paying their Medicare prescription drug plan costs. (See **Help with Medicare Prescription Drug Plan Costs** for more details.)

These materials were prepared in March 2005 by the Centers for Medicare & Medicaid Services. They are intended for training purposes only and are not legal documents.

Definition can be found in the glossary.

IF YOU WANT TO KNOW MORE

Medicare Advantage Plans

Medicare & You

Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure)

Medicare Advantage Plans offer additional health plan choices to people with Medicare.

MEDICARE ADVANTAGE PLANS

Basics

With a Medicare Advantage Plan, Medicare pays a set amount of money for your care every month to a private health plan that manages Medicare coverage for its members. Some plans may pay for part or all of your Medicare Part B premium cost.

Types of Medicare Advantage Plans

There are different types of Medicare Advantage Plans, including:

- Medicare Managed Care Plans (HMO)
- Medicare Preferred Provider Organization Plans
- Medicare Private Fee-for-Service Plans
- Medicare Specialty Plans

In most **Medicare Managed Care Plans**, there are doctors and hospitals that join the plan, called the plan's network. You will need to get most of your care and services from the plan's network. Referrals are required for most services and to see doctors outside this network. You may pay more, or services may not be covered, when you get health care outside the plan's network. Rules may differ among plans, so it's important to read your plan materials carefully.

Medicare Preferred Provider Organization (PPO) Plans have many of the same features as Medicare Managed Care Plans. In a PPO, however, referrals are not necessary to see a specialist or out-of-network provider. You may need plan approval before receiving certain services and may pay more if you go to doctors, hospitals, or other providers that aren't part of the PPO Plan.

Under **Medicare Private Fee-for-Service (PFFS) Plans**, a private company, rather than Medicare, decides how much it will pay and how much you will pay for the services you receive. If you join one of these plans, you can go to any doctor or hospital that accepts the plan's payment terms. No referrals are necessary.

Medicare Specialty Plans (SP) are designed to provide Medicare health care, as well as more focused care for specific groups of people or individuals with certain medical conditions. For example, these plans may be for people in certain long-term care facilities or for people who qualify for both Medicare and Medicaid.

Who Can Join a Medicare Advantage Plan

Medicare Advantage Plans are available to most people with Medicare.

You can join a Medicare Advantage Plan if:

- You have both Medicare Part A and Medicare Part B and continue to pay the monthly Medicare Part B premium
- You live in the plan's service area
- You don't have End-Stage Renal Disease (some exceptions apply)

When You Can Join

You can join a Medicare Advantage Plan when you first join Medicare if a plan is available in your area and is accepting new members. You are eligible for Medicare the first day of the month you turn 65.

Or, if you already have Medicare (for example, the Original Medicare Plan) in 2005 and decide to join a Medicare Advantage Plan later, you can join at any time if the plan is open to new members. Your coverage usually begins the month after the plan receives your enrollment form.

Note: In some cases, a Medicare Advantage Plan will only accept new members during the annual enrollment period from November 15 to December 31. Beginning January 1, 2006, there will be new rules about when you may join or leave a Medicare Advantage Plan.

While you are in a Medicare Advantage Plan, you still have Medicare rights and protections, as well as all of your regular Medicare-covered services offered under Part A and Part B.

You May Need to Know

- Some Medicare Advantage Plans may offer additional benefits or require an additional monthly premium payment.
- You may only belong to one Medicare Advantage Plan at a time.
- If you join a Medicare Advantage Plan and also have coverage from your employer or union, you may still be able to use this coverage along with your Medicare Advantage Plan. It is important to talk to your employer or union benefits administrator about the rules that apply. Keep in mind that if you drop your employer or union coverage, you may not be able to get it back.
- If you already have a **Medigap (Medicare Supplement Insurance)** policy and join a Medicare Advantage Plan, you can keep the Medigap policy, but it may cost you a lot and provide little or no benefit while you are in a Medicare Advantage Plan. You can your local **State Health Insurance Assistance Program (SHIP)** if you need help deciding whether to keep your Medigap policy. Call **1-800-MEDICARE** (1-800-633-4227) to get the number of the SHIP in your area.
- In 2006, the **Medicare Modernization Act** provides for ***regional PPOs***. This gives all people with Medicare additional choices for Medicare health care coverage. Regional PPOs will limit the maximum amount that a member will pay for care outside the network.

Medicare Advantage and Medicare Prescription Drug Coverage

People enrolled in a Medicare Advantage HMO, PPO, or SNP can receive their prescription drug coverage through a Medicare Advantage Prescription Drug (MA-PD) plan. If you are currently in a Medicare Advantage Plan without prescription drug coverage, you will need to obtain coverage through a Medicare Advantage Prescription Drug (MA-PD) plan. If you are enrolled in a Medicare Advantage PFFS plan, you will need to enroll in a Medicare prescription drug plan to get drug coverage.

For More Information

For more information about the plans available in your area and how to join a plan, call **1-800-MEDICARE** (1-800-633-4227) or visit **www.medicare.gov** on the Web.

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IF YOU WANT TO KNOW MORE

Medicaid

Medicare & You

Medicaid is a joint Federal and state program that helps with medical costs for:

- Some people with low incomes and limited resources, and
- Certain people with disabilities.

The Federal government sets general guidelines for the Medicaid program, while each state sets specific requirements. Medicaid programs vary from state to state, but if you qualify for both Medicare and Medicaid, most health care costs are covered.

Basics

States are required to include certain individuals or "eligibility" groups under their Medicaid plans. They may choose to include other groups. States are required to cover the groups listed below.

- In most cases, you must be a pregnant woman, a child, a member of a limited income family, or must be aged, blind, or disabled.
- You must meet state income and resource standards, and certain other requirements.
- You must be a resident of the state, and be a U.S. citizen or a qualified immigrant. Legal immigrants can also qualify under certain circumstances depending on their date of entry into the country. Undocumented aliens can't qualify, except for emergency care.

Income Limits and Medicaid

The amount of money you can make and still get Medicaid varies depending on the eligibility group you fall into. Each state sets an income limit for each Medicaid eligibility group and determines what income counts towards that limit. Contact your local Medicaid office or your state to find out what the income limits are and how much of your income counts.

Applying for Medicaid

You apply for Medicaid in the state in which you live. You can obtain and submit an application at your local Medicaid office. The telephone number for your local office can be found in the telephone book or by calling **1-800-MEDICARE** (1-800-633-4227).

Some states let you apply on the Internet, by telephone, or at locations in the community, such as community health centers.

Most states have a toll-free number to help answer your questions. The toll-free operators can provide you information on how and where to apply. You can find the state contact information at **www.cms.hhs.gov/medicaid/statemap.asp** on the Web by selecting your state program from the map.

Medicaid and Medicare Prescription Drug Coverage

Starting January 1, 2006, if you have both Medicare and full Medicaid benefits, you will no longer receive drug coverage through Medicaid. Medicare will provide your prescription drug coverage instead of Medicaid. You can enroll beginning November 15, 2005. If you have Medicare and full Medicaid benefits and don't choose a Medicare prescription drug plan by December 31, 2005, Medicare will enroll you in one. However, you will be able to change plans at any time. Some state Medicaid programs may cover those prescriptions that won't be covered under a Medicare prescription drug plan. For more information, contact your state's Medicaid program.

Medicaid Coverage for Breast and Cervical Cancer Prevention and Treatment

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 allows states the option to provide full Medicaid coverage to women who otherwise would not have health care coverage for breast and/or cervical cancer for the duration of their treatment. For further information about BCCPTA, visit **www.cms.hhs.gov/bccpt/default.asp** on the Web.

You May Need to Know

To find the telephone number for the local Medicaid office, visit **www.cms.hhs.gov/medicaid/mcontact.asp** on the Web, or call your local Social Security office.

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IF YOU WANT TO KNOW MORE

Medigap and Other Supplemental Insurance

Medicare & You

If you are in the Original Medicare Plan, you may want to buy a Medigap policy. A Medigap policy may help you lower your out-of-pocket costs.

The type of Medigap policy you buy can affect:

- How much you pay,
- What benefits you may have, and
- Which doctors you can see.

In addition, there are other programs that can help lower your health care costs.

MEDIGAP

Basics

A Medigap policy is a health insurance policy sold by private health insurance companies to help pay for some of the health care costs ("gaps") that the **Original Medicare Plan** doesn't cover.

There are 12 standardized Medigap policies, called **Plans "A" through "L."** Each plan has a different set of benefits. You can easily compare policies from company to company because the plans are standardized. Each policy is different, but not all insurance companies sell all 12 policies. Call **1-800-MEDICARE** (1-800-633-4227) to get the number of the **State Health Insurance Assistance Program** in your state for help in choosing a policy.

Who Can Get a Medigap Policy

In most cases, you must have both Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare to buy a Medigap policy.

You May Need to Know

- By law, insurance companies may only sell one standardized policy at a time to a person with Medicare.
- If you have Medicaid, it is illegal in most cases for an insurance company to sell you a Medigap policy.
- You don't need to buy a Medigap policy if you are in a Medicare Advantage Plan.

Buying a Medigap Policy

While people with Medicare aren't required to buy Medigap policies, you may want to buy a policy if you choose to enroll in the Original Medicare Plan (Part A and Part B) to help pay some of the health care costs the Original Medicare Plan doesn't cover.

The best time to buy a Medigap policy is during your Medigap open enrollment period. The open enrollment period is the 6 months starting on the first day of the month in which you are age 65 or older and are enrolled in Medicare Part B.

Medigap and the New Medicare Prescription Drug Coverage

Beginning in the fall of 2005, all private companies that sell Medigap policies with prescription drug coverage, plans H, I, and J, must send a notice to those policyholders telling them whether or not their coverage is at least as good as coverage through a Medicare prescription drug plan. If you receive one of these notices, it will explain your rights and choices.

Starting January 1, 2006, when Medicare prescription drug plans begin coverage, you won't be able to buy Medigap policies covering prescription drugs. If you currently have a Medigap policy with prescription drug coverage, you have several options to choose from to continue getting prescription drug coverage, including enrolling in a Medicare prescription drug plan. You should make a decision about how to get your prescription drug coverage before May 15, 2006. Read the notice from your Medigap insurer carefully and consider all of your options.

For More Information

- If you have a Medigap policy, contact your Medigap insurer for information about your Medigap policy options.
- For more information about Medigap policy costs and choices, call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048. You may also find information about Medigap policies at **www.medicare.gov** on the Web.
- In the fall of 2005 you will be able to get personalized information to help you find a Medicare prescription drug plan that meets your needs, by visiting **www.medicare.gov** or by calling **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048.

Other Supplemental Insurance

Employer or Union Health Coverage

You can contact your or your spouse's current or former employer or union to find out if you can get health coverage through past or current employment.

(See **Employment-Related Drug Coverage** for information about employer/union retiree drug coverage.)

It is important to note that when you have employer or union health coverage and drop it, you may not be able to get it back. Check with your employer's or union's benefits administrator for more information.

Veterans' Benefits

If you are a veteran or have had any U.S. military service, call the U.S. Department of Veterans Affairs at 1-800-827-1000 for information about veterans' benefits and services available in your area.

Military Retiree Benefits

TRICARE is a health care program for active duty and retired uniformed services members and their families. In general, Medicare pays first for Medicare-covered services. If Medicare doesn't pay the entire bill, TRICARE may pay some of the costs as the second payer. You are also eligible for drug coverage through the TRICARE Senior Pharmacy Program. Call 1-800-538-9552 for more information.

Medicare Savings Programs

There are programs that help people with Medicare save money each year. States have programs for people with limited income and resources that pay Medicare premiums, and may also pay Medicare deductibles and coinsurance, in some cases. Call **1-800-MEDICARE** (1-800-633-4227) for more information about Medicare Savings Programs. **Note:** Medicare Savings Programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

Medicaid

Medicaid is a joint Federal and state program that helps pay medical costs for some people with limited incomes and resources. Medicaid programs vary from state to state. For more information about Medicaid, call your state Medicaid office.

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IF YOU WANT TO KNOW MORE

Disability & End-Stage Renal Disease

Medicare & You

Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease* (permanent kidney failure)

There are special benefits and guidelines for those entitled to Medicare because of a disability or End-Stage Renal Disease (ESRD). You can get more information by calling:

- Social Security at 1-800-772-1213
- 1-800-MEDICARE (1-800-633-4227)

Or on the Web at:

- www.socialsecurity.gov
- www.medicare.gov
- www.cms.hhs.gov

MEDICARE BASED ON A DISABILITY

Basics

Most people, including people with disabilities, become eligible for Medicare because of their entitlement to Social Security benefits.

To be eligible for Social Security disability benefits, you must have a medical condition that:

- keeps you from working and
- is expected to last at least a year or result in death.

You must be unable to do your previous work and any other type of work, considering your age, education, and experience. Different rules apply if you are blind.

If you have a disability, you have the same Medicare health plan choices and coverage as people age 65 and older. You may choose the **Original Medicare*** Plan or a **Medicare Advantage*** Plan.

Eligibility and Enrollment

To be eligible for benefits, in addition to being disabled, you must have earned the required number of work credits during the last 10 years you were able to work. (People can earn up to four work credits per year.) Or you may be able to get benefits as a disabled widow or widower or as the disabled child of a worker who paid into Social Security. Qualified government employees, railroad employees, and others with disabilities may be eligible for Medicare, but the rules may be different.

To apply for benefits, call Social Security at **1-800-772-1213** or contact your local Social Security office. Contact the Railroad Retirement Board if you are a railroad employee.

For most people, there are two waiting periods:

- Social Security disability benefits begin 5 full calendar months after your disability starts.
- Medicare begins 24 months after your benefits begin.

As long as you continue to meet the requirements for Social Security disability benefits, you continue to be entitled to Medicare. If your benefits stop because your condition improves, your Medicare entitlement based on disability ends.

You May Need to Know

- The 24-month waiting period for Medicare doesn't apply to people who have Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's Disease). People with ALS get Medicare the first month they are entitled to disability benefits.
- You will need to decide if you want to enroll in Part B. You may not need Part B if you have an employer group health plan based on current work by a spouse or a parent. Before you decide, call Social Security at **1-800-772-1213** or Medicare at **1-800-633-4227** to be sure you won't be charged a higher premium if you later decide you do want Part B.
- Some people with disabilities who have limited income and resources may be able to get Supplemental Security Income or SSI. SSI is different from Social Security.
- Social Security has **work incentives** to help people who try to work in spite of their disability. Being able to keep Medicare is one type of work incentive.

MEDICARE BASED ON ESRD

Basics

End-Stage Renal Disease (ESRD) is a kidney condition that causes permanent kidney failure and requires regular dialysis* or a kidney transplant.

For most people, Medicare coverage begins the fourth month of dialysis treatments or the month you are admitted to a hospital for a kidney transplant. The facility must be approved by Medicare, and certain other conditions must be met.

If you have Medicare based on ESRD, you can get all Medicare covered services. In addition, special services are available for those with ESRD.

Eligibility and Enrollment

You can get Medicare Part A at any age if you have ESRD and:

- You have worked the required amount of time; or
- You are eligible for Social Security or Railroad Retirement benefits; or
- You are the spouse or dependent child of someone who has worked the required amount of time.

To apply, call the Social Security Administration at **1-800-772-1213**.

Enrolling in Medicare Part B is your choice. You will need both Part A and Part B for coverage of certain dialysis and kidney transplant services.

If you have Medicare because of ESRD, your coverage will end if you no longer need dialysis for 12 months, or if 36 months after a successful transplant.

You May Need to Know

- If you can't get Medicare, you may be able to get help from your state to pay for dialysis treatments.
- You may want to delay enrolling in Medicare if you have a group health plan.
- Immunosuppressive drug therapy* for people who receive a kidney transplant is covered by Medicare ONLY if:
  - Part A paid for the transplant or was secondary payer, and
  - You have Part B when you receive immunosuppressive drug therapy.
- In most cases, Medicare doesn't pay for:
  - Aides to help with home dialysis
  - Lost pay
  - A place to stay during treatment
  - Blood for home dialysis
  - Transportation to the dialysis facility
- The ESRD networks are excellent sources of information. Look for contact information in the Medicare publication ***Medicare Coverage of Kidney Dialysis and Kidney Transplant Services***. You can also get information about Medicare-certified dialysis facilities at **www.medicare.gov** by clicking "Compare Dialysis Facilities in Your Area."

Definition can be found in the glossary.

IF YOU WANT TO KNOW MORE

Preventive Services

Medicare & You

Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure)

MEDICARE-COVERED PREVENTIVE SERVICES

Basics

Medicare pays for many preventive services to help keep you healthy. Preventive services can find health problems early when treatment works best and can keep you from getting certain diseases or illnesses. Preventive services include exams, lab tests, screenings, shots, and monitoring and information to help you take care of your health. These preventive services are covered by all Medicare health plans, but the amount you pay may vary.

"Welcome to Medicare" Physical Exam

Medicare will help pay for a one-time initial physical exam including:

- height and weight,
- blood pressure,
- electrocardiogram,
- education and counseling, and
- referrals for other services.

How Often is it Covered?
Once within the first 6 months you have Part B.

Who is Covered?
All people whose Medicare Part B begins on or after January 1, 2005.

Costs in the Original Medicare Plan?
After the yearly Part B deductible ($110 for 2005), 20% of the Medicare-approved amount.

Cardiovascular Screening

Medicare covers cardiovascular screenings that check your cholesterol and other blood fat (lipid) levels. High cholesterol can increase your risk for heart disease and stroke.

How Often is it Covered?
Every 5 years.

Who is Covered?
All people with Medicare.

Costs in the Original Medicare Plan?
Nothing.

Diabetes Screening

Medicare covers a screening blood sugar test to check for diabetes. When you have diabetes, your body doesn't make enough insulin or has a reduced response to insulin, which causes your blood sugar to be too high.

How Often is it Covered?
Up to twice a year.

Who is Covered?
People with Medicare who have high blood pressure, abnormal cholesterol and triglyceride levels, obesity, a history of high blood sugar, or two or more of the following characteristics:

- age 65 or older,
- overweight,
- family history of diabetes, or
- history of diabetes during pregnancy or delivering a baby over 9 pounds.

Costs in the Original Medicare Plan?
Nothing for screening tests. For certain diabetes supplies and self-management training for people with diabetes, 20% of the Medicare-approved amount after the yearly Part B deductible.

OTHER MEDICARE-COVERED PREVENTIVE SERVICES

Bone Mass Measurements

Medicare covers bone mass measurements to determine if you are at risk for broken bones because of osteoporosis.

How Often is it Covered?
Once every 24 months (more often if medically necessary).

Who is Covered?
All people with Medicare who are at risk. Your risk for osteoporosis increases if you:

- are a woman age 50 or older,
- have a personal history or family history of broken bones,
- are White or Asian,
- are small-boned or have low body weight,
- have a low-calcium diet, or
- smoke or drink a lot.

Costs in the Original Medicare Plan?
After the yearly Part B deductible, 20% of the Medicare-approved amount.

Breast Cancer Screening Mammograms

Medicare covers screening mammograms and digital technologies for screening mammograms to check for breast cancer. Every woman is at risk for breast cancer, and the risk increases with age.

How Often is it Covered?
Once every 12 months.

Who is Covered?
All women with Medicare age 40 and older. Also one baseline mammogram for women with Medicare between ages 35 and 39.

Costs in the Original Medicare Plan?
20% of the Medicare-approved amount (no Part B deductible).

Cervical and Vaginal Cancer Screening

Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. A breast exam to check for breast cancer is covered along with the pelvic exam.

How Often is it Covered?
Once every 24 months (every 12 months for women at high risk).

Who is Covered?
All women with Medicare.

Costs in the Original Medicare Plan?
Nothing for the Pap lab test. For Pap test collection and pelvic and breast exams, 20% of the Medicare-approved amount (no Part B deductible).

Colorectal Cancer Screening

Medicare covers colorectal screening tests to help find precancerous growths so they can be removed before they turn into cancer.

How Often is it Covered?

- Fecal occult blood test, every 12 months
- Flexible sigmoidoscopy, every 48 months
- Screening colonoscopy, every 24 months (if high risk) or every 10 years, in most cases
- Barium enema, every 24 months (if high risk) or every 48 months

Who is Covered?
All people with Medicare age 50 and older (no minimum age for a screening colonoscopy).

Costs in the Original Medicare Plan?
Nothing for the fecal occult blood test. For other tests, 20% of the Medicare-approved amount after the yearly Part B deductible (25% if a flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department).

Glaucoma Screening

Medicare covers tests for glaucoma, a disease caused by high pressure in the eye that can cause you to gradually lose sight without warning and often without symptoms.

How Often is it Covered?
Once every 12 months.

Who is Covered?
People with Medicare at high risk for glaucoma. Your risk for glaucoma increases if you have diabetes, have a family history of glaucoma, or are African American and age 50 or older.

Costs in the Original Medicare Plan?
20% of the Medicare-approved amount after the yearly Part B deductible.

Prostate Cancer Screening

Medicare covers tests to detect prostate cancer so it can be treated early, including testing the amount of PSA (Prostate Specific Antigen) in your blood and rectal exams.

How Often is it Covered?

- Digital rectal exam, every 12 months
- PSA test, every 12 months

Who is Covered?
All men with Medicare over age 50 (coverage begins the day after you turn 50).

Costs in the Original Medicare Plan?
Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA test.

Flu, Pneumococcal, and Hepatitis B Shots

Flu, pneumococcal infections, and Hepatitis B can be life threatening to an older person.

Flu Shot
Covered once a flu season for all people with Medicare; you pay nothing in the Original Medicare Plan.

Pneumococcal Shot
One shot may be all you will ever need. All people with Medicare are covered and you pay nothing in the Original Medicare Plan.

Hepatitis B Shots
Covered for people with Medicare at risk for Hepatitis B. Three shots are needed for complete protection—check with your doctor. 20% of the Medicare-approved amount after the yearly Part B deductible in the Original Medicare Plan.

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IF YOU WANT TO KNOW MORE

Help with Medicare Prescription Drug Plan Costs

Medicare & You

Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure)

Beginning January 1, 2006, Medicare will offer prescription drug coverage. Starting November 15, 2005, all people with Medicare can enroll in a plan that covers prescription drugs. People with limited incomes and resources (including your savings, stocks, and bonds, but not counting your home) may be able to get extra help with drug plan costs.

HELP WITH MEDICARE PRESCRIPTION DRUG PLAN COSTS

Basics

This assistance is designed to provide extra help with Medicare prescription drug plan premiums, deductibles, and copayments—an average of $2,100 a year—for people with Medicare. Both income and resources are used to determine your eligibility for this help.

Counting Income

Income is counted the same way as the rules for the Supplemental Security Income (SSI) program. Your husband's or wife's income is counted if he or she is living with you, even if he or she isn't applying for the extra help. Contact the Social Security Administration for more information on income rules.

Counting Resources

Resources are counted for you and your husband or wife living with you somewhat differently from the SSI program. Only two types of resources are considered for this extra help:

- Liquid assets (e.g., savings accounts, stocks, bonds, and other funds that could be changed to cash within 20 days).

- Real estate (land or property) that is not your primary residence.

Items such as vehicles, wedding rings, and family heirlooms are not considered assets for purposes of the help with Medicare prescription drug plan costs.

Three groups may be eligible for help with Medicare prescription drug plan costs (income amounts are higher in Alaska and Hawaii):

- **Group 1**—People with Medicare and full Medicaid benefits with incomes at or below 100% of the Federal poverty level ($798 per month for a single person and $1,070 per month for a married couple in 2005).
- **Group 2**—People with Medicare and full Medicaid benefits with income above 100% of the Federal poverty level; and other people with Medicare with incomes below 135% of the Federal poverty level ($1,077 per month for a single person and $1,444 per month for a couple in 2005), with resources no greater than $7,500 for a single person or $12,000 for a married couple.
- **Group 3**—People with Medicare with incomes below 150% of the Federal poverty level ($1,197 per month for a single person and $1,604 per month for a couple in 2005), with resources no greater than $11,500 for an individual or $23,000 for a married couple.

Help for Group 1

You don't have to pay the monthly premium or the deductible. You only have small copayments of $1 for generic drugs and $3 for brand-name drugs. If the low-income assistance plus these copayments total $3,600, you won't have to pay any other costs for the rest of the year.

Help for Group 2

You don't have to pay the monthly premium or the deductible. You'll have a $2 copayment for generic drugs and a $5 copayment for brand-name drugs. If the low-income assistance plus these copayments total $3,600, you won't have any other costs for the rest of the year.

Help for Group 3

Your monthly premium will be less and will be based on your income. You'll be responsible for a reduced deductible of $50 per year, and you'll be responsible for 15% of the cost of your prescriptions up to the $3,600 out-of-pocket maximum. Once these payments plus your low-income assistance reach that maximum, you'll have a $2 copayment for generic drugs and a $5 copayment for brand-name drugs for the rest of the year.

Eligibility and Enrollment

Eligibility for this extra help may be determined by either the Social Security Administration or your state Medicaid office. You can apply for the extra help by:

- Completing a form Social Security is mailing to people who may be eligible.
- Applying on the Social Security website.
- Applying through events sponsored by the Social Security Administration.
- Applying through the state Medicaid office.
- Working with a local organization, such as your State Health Insurance Assistance Program (SHIP).

You, your legal representative, or your representative payee may apply for the extra help, or you may ask someone else to apply for you.

In the summer of 2005, the Social Security Administration will mail information and an application for the extra help to people who may qualify. If you get an application, it is important that you fill it out and send it back as soon as possible.

Even if you don't receive an application from SSA, you may qualify for the extra help. If you think you qualify and don't get an application, visit the Social Security website at **www.socialsecurity.gov** or call **1-800-772-1213** and ask for one.

When you apply, you will be asked for information about your income and resources and you will be asked to sign a statement that your answers are true. Social Security will check your information from computer records at the Internal Revenue Service and other sources. You may be contacted if more information is needed.

When your application has been processed, you will get a letter telling you if you qualify for the extra help.

Certain groups of people with Medicare will automatically qualify for this extra help and don't have to apply:

- People with Medicare and full Medicaid benefits.
- People with Medicare receiving Supplemental Security Income (SSI).
- People who belong to a Medicare Savings Program (contact your state for more information about these programs).

You will receive a notice from Medicare if you automatically qualify for this extra help. **If you don't receive a notice saying you automatically qualify, you must apply.**

Once you qualify for the extra help, you still need to enroll in a Medicare prescription drug plan.

- **If you have Medicare and full Medicaid benefits,** you need to choose and enroll in a Medicare prescription drug plan to get extra help with your prescription drug costs. If you don't enroll in a plan by December 31, 2005, Medicare will enroll you in one. Your coverage will begin on January 1, 2006. If the plan you are enrolled in does not meet your needs, you can change plans at any time.
- **If you belong to a Medicare Savings Program or get Supplemental Security Income (SSI)**, you need to choose and enroll in a Medicare prescription drug plan to get extra help with your prescription drug costs. If you don't enroll in a plan by May 15, 2006, Medicare will help you enroll you in one. Your coverage will begin on June 1, 2006.
- **If you have applied for and are found eligible for the low-income assistance** and don't choose a plan by May 15, 2006, Medicare will help you enroll in a plan effective June 1, 2006.

You May Need to Know

- State Pharmacy Assistance Programs may provide extra help with drug plan costs for their members who sign up for Medicare prescription drug coverage. Contact your state program for more information.
- If you are in a long-term care facility such as a nursing home, or belong to a PACE program (Program of All-Inclusive Care for the Elderly) and enroll in a Medicare plan offering prescription drugs, you won't pay anything for prescription drugs.

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IF YOU WANT TO KNOW MORE

Medicare Prescription Drug Coverage

Medicare & You

Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure)

Beginning January 1, 2006, Medicare will offer prescription drug coverage. Most people will be able to get this coverage through Medicare prescription drug plans. Medicare will also work with employers and unions to ensure that people who currently receive drug coverage through their former employer or union can continue to do so.

Starting November 15, 2005, all people with Medicare can enroll in a plan that covers prescription drugs. Medicare will work with insurance companies and other private companies to offer these drug plans. The companies will negotiate discounts on drug prices on behalf of the people who enroll. Every person with Medicare will have a choice of at least two drug plans that cover both brand-name and generic drugs. There will be extra help for those who need it most.

MEDICARE PRESCRIPTION DRUG COVERAGE

Basics

Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance, if you join, you will pay a monthly premium, generally about $37, plus a share of the cost of your prescriptions. Costs may be different depending on the drug plan you choose.

Drug plans may vary in the prescription drugs covered, how much you have to pay, and the pharmacies you can use. All drug plans will have to provide at least a standard level of coverage, which Medicare will set. However, some plans may offer more coverage and additional drugs for a higher monthly premium. When you join a drug plan, it's important for you to choose one that meets your needs. Some employers or other third parties may offer coverage that supplements the standard coverage.

If you are in fee-for-service Medicare and want Medicare prescription drug coverage, you will need to sign up for a prescription drug plan. These plans may vary in coverage. Generally, standard coverage works like this:

- You pay a $250 deductible
- You pay 25% of drug costs from $250 to $2,250; Medicare will pay 75 percent
- You pay 100% of drug costs from $2,250 to $5,100
- After your total drug costs reach $5,100 and you have paid $3,600 in out-of-pocket costs, you pay only 5% of any costs above $5,100; Medicare will pay the other 95 percent

In most cases, if you are enrolled in a **Medicare Advantage Plan**, (like an HMO or PPO), you will receive your Medicare prescription drug coverage through that plan.

Medicare will provide information about Medicare prescription drug plans, including how to choose and join a plan. In the fall of 2005, Medicare will mail you the ***Medicare & You 2006*** handbook, which will list the Medicare prescription drug plans available in your area.

Extra Help for Those Who Need it Most

If you have a limited income and resources, which includes your savings and stocks, but not your home, you may be able to get extra help. If you qualify, you will get help paying the monthly premium for your drug plan and/or some of the other costs for your prescriptions. The type of extra help will be based on the amounts of your income and resources.

In the summer of 2005, the Social Security Administration will send people with limited incomes information about how to apply for this extra help. If you think you qualify, you can apply with Social Security as early as summer 2005.

Eligibility and Enrollment

If you have Medicare Part A and/or Part B, you can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. If you join by December 31, 2005, your Medicare prescription drug coverage will begin on January 1, 2006. If you join after that, your coverage will begin the first day of the month after the month you join.

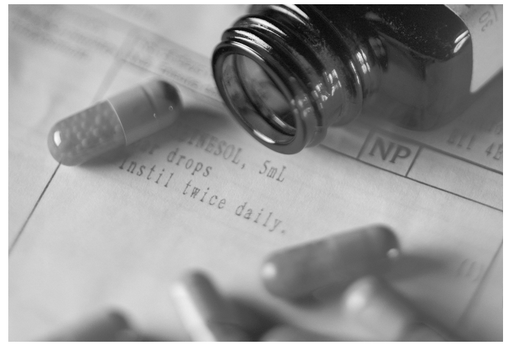
To enroll in a plan, you must live in the plan's service area. You can enroll directly in a plan, or someone else can help you enroll. The plan will notify you if your application is accepted or not.

It is important that you join a Medicare prescription drug plan when you are first eligible. Medical practice has come to rely more and more on new drug therapies to treat chronic conditions, and out-of-pocket spending on drugs has increased dramatically. Most people with Medicare currently need or will come to need prescription drugs to stay healthy. Medicare prescription drug coverage will protect you from high out-of-pocket costs. For most people, joining when you are first eligible means that you will pay a lower monthly premium than if you wait to join later.

After May 15, 2006, you can enroll in a plan, drop a plan, or change plans only during the period November 15 through December 31 each year, except in certain situations. If you want to stay in the plan you are currently enrolled in for the next year, you don't have to do anything.

You May Need to Know

- As of January 2006, if you have both Medicare and full Medicaid benefits, you will no longer receive drug coverage through Medicaid. Medicare will provide your prescription drug coverage instead of Medicaid. If you have Medicare and full Medicaid benefits and do not choose a plan by December 31, 2005, Medicare will enroll you in one. However, you will be able to change plans at any time.
- Medicare prescription drug plans are different from the Medicare-approved drug discount cards that were available in 2004 and 2005. You can use your Medicare-approved drug discount card until May 15, 2006, or until you join a Medicare prescription drug plan—whichever is first.
- If you have a **Medigap (Medicare Supplement)** policy with drug coverage, you will get a notice from your insurance company telling you whether or not your policy is as good as or better than Medicare prescription drug coverage. This notice will explain your rights and choices.
- If you have prescription drug coverage from an employer or union, your employer or union will notify you about whether your current drug coverage is as good as or better than Medicare prescription drug coverage. If it is, you can keep your current drug coverage, and if you decide to join a Medicare prescription drug plan later, your monthly premium won't be higher. If you drop your current drug coverage and join a Medicare prescription drug plan, you may not be able to get your employer or union drug coverage back.
- If you live in a U.S. territory and have a limited income and limited resources, you may get extra help paying for your prescription drug costs.
- If you are in a nursing home, you may get your prescription drugs from a long-term care pharmacy that contracts with a Medicare prescription drug plan.
- Your Medicare prescription drug plan must notify you 60 days before taking one of your prescriptions off its list of covered drugs.
- In the fall of 2005 you will be able to get personalized information to help you find a plan that meets your needs by visiting **www.medicare.gov** or by calling **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048. Your **State Health Insurance Assistance Program (SHIP)** and other local organizations will also be able to help you with your drug coverage decisions.



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IF YOU WANT TO KNOW MORE

Employment-Related Drug Coverage

Medicare & You

Medicare is a health insurance program for:

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- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure)

Starting January 1, 2006, Medicare will offer insurance coverage for prescription drugs to all people with Medicare. Most people will be able to get this coverage through Medicare prescription drug plans. Medicare will also work with employers and unions to ensure that people who currently receive drug coverage through their former employer or union can continue to do so. Check with your employee benefits administrator before considering a Medicare prescription drug plan.

EMPLOYMENT-RELATED PRESCRIPTION DRUG COVERAGE

Basics

Employers and unions that offer plans with drug coverage to their retirees are required to notify their retirees with Medicare whether that drug coverage is at least as good as Medicare prescription drug coverage. If you have employer or union drug coverage of any kind and don't receive this information, you have the right to ask for it. Check with your benefits administrator to see how your employer/union drug coverage compares to Medicare drug coverage. In some cases the employer/union coverage may pay significantly more of your drug costs.

The notice from your employer or union will explain your rights and choices. If your current drug coverage is at least as good as Medicare prescription drug coverage, you can keep your current drug coverage, and if you decide to join a Medicare prescription drug plan later, your monthly Medicare drug premium won't be higher. If you drop your employer/union drug coverage and join a Medicare prescription drug plan, you may not be able to get your employer or union drug coverage back. In addition, in some employer and union plans, you can't drop drug coverage without also dropping other medical coverage (such as coverage for hospital and physician services). Talk to your benefits administrator to make sure you understand your rights and choices before you make a change.

Finally, if you have limited income you may be eligible for extra help with Medicare prescription drug plan costs. Employer and union coverage that is at least as good as the standard Medicare prescription drug coverage may not pay as much of your drug costs as Medicare would pay including this extra help. Ask your benefits administrator to help you compare so you can choose the coverage that is best for you.

Your Options

- If your employer or union plan covers **as much as or more than** Medicare prescription drug coverage, you can:
  - Keep your current drug plan. If you join a Medicare prescription drug plan later, your monthly premium won't be higher.
    Or
  - Enroll in a Medicare prescription drug plan. Be sure you understand what effect this will have on your employer/union coverage. If you drop your employer/union coverage you may not be able to get it back later.
- If your employer or union plan covers **less than** Medicare prescription drug coverage, you can:
  - Keep your current drug plan and join a Medicare prescription drug plan to give you more complete prescription drug coverage. Some employers and unions plan to offer drug coverage specifically designed to supplement the new Medicare drug benefit. Talk to your benefits administrator to see if your coverage is intended to supplement the Medicare drug benefit.
    Or
  - Just keep your current drug plan. But if you wait to join a Medicare prescription drug plan later, you may have to pay a higher premium.
    Or
  - Drop your current drug plan and join a Medicare prescription drug plan. But remember that you may not be able to get your employer or union drug coverage back later.
- If your employer or union stops offering drug coverage at a later date, or the coverage is no longer at least as good as the new Medicare prescription drug coverage, you will be able to enroll in a Medicare prescription drug plan without paying a higher monthly premium.

- It is important that you join a Medicare prescription drug plan when you are first eligible. Medical practice has come to rely more and more on new drug therapies to treat chronic conditions, and out-of-pocket spending on drugs has increased dramatically. Most people with Medicare currently need or will come to need prescription drugs to stay healthy. Medicare prescription drug coverage will protect you from high out-of-pocket costs. For most people, joining when you are first eligible means that you will pay a lower monthly premium than if you wait to join later.

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IF YOU WANT TO KNOW MORE

State-Specific Information

Medicare & You

Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure)

Starting January 1, 2006, all people with Medicare can enroll in a plan that covers prescription drugs.

Your state may have special programs or procedures that relate to the new Medicare prescription drug coverage. This folder is provided for you to store the state-specific materials you need to help people decide about enrolling in a Medicare prescription drug plan.

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